The Health of New Hampshire's Community Hospital System

A Financial Analysis

Franklin Regional Hospital




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An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

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Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire.*

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

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For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

FRANKLIN REGIONAL HOSPITAL, FRANKLIN, NEW HAMPSHIRE 1993 – 1999 FINANCIAL ANALYSIS

Franklin Regional Hospital is a 49-bed, acute-care facility serving Merrimack County[3]. As of 1997, Medicare followed by private insurers represented the largest percentage of payers for inpatient discharges (55 and 28%, respectively)[4].

After 1995, financial statements report data for Franklin Regional Hospital and purchased physician practices, referred to as the Franklin Regional Hospital Association.

Summary of Financial Analysis 1993-98
Franklin Regional Hospital's financial performance over this six-year period has been deteriorating, particularly since the acquisition of physician practices in October, 1995. Decreasing debt service indicators are a red flag and may cause near-term concern for the hospital's financial viability. Slow collection and poor profitability have negatively affected the hospital's liquidity as well.

Cash Flow Analysis 1993-98
The hospital's second-largest source of cash was long-term borrowing, augmenting cash from depreciation (46% of total cash sources) to generate cash for investing needs. After repayment of outstanding debt, the increase in long-term borrowing generated 29% of the hospital's total cash over the period, more than that provided by net income (20%). This is an unhealthy pattern of cash sources, especially for a small hospital with low and unsteady profit margins and slow collection of receivables.

Half of total cash uses were in property, plant and equipment (PP&E). This level of investment ($5.8M) was slightly above depreciation expense ($5.2M), and seemed adequate given the young average age of plant of 6.2 years in 1998. However, the hospital had to increase its level of financial risk considerably to maintain its plant. The second highest use was to increase trustee-held marketable securities, which are reserves held to service debt required by contractual agreements. Working capital represented a net cash outflow because the hospital was very slow to collect its accounts receivable, an unfavorable trend reflected in the growth in days in accounts receivable measure from 76 to 91 days by 1998.

This pattern of cash sources and uses indicate increased financial risk and decreased liquidity for this small hospital.

Ratio Analysis 1993-98[5]
Profitability
The hospital's profitability eroded to low levels in recent years. Following the acquisition of physician practices in 1995, Franklin experienced a sharp decline in what had been strong profitability. Prior to 1995, the hospital enjoyed strong profit margins (8 to 9%) driven by high and stable operating profitability (7% operating margins). By 1996, operating margins completely eroded, and operating losses persisted through 1998. The hospital was able to use nonoperating gains to achieve positive margins, but by 1998 even these gains were not enough to

[3] The 1998 American Hospital Association Guide.
[4] 1997 data from the State of New Hampshire Department of Health and Human Services.
[5] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

offset operating losses. This deterioration appears at least partly due to the performance of the physician practices owned by the hospital, which lost over $500,000 in 1996 and 1997, and $478,000 in 1998.

Liquidity

The hospital's liquidity deteriorated over the period at a time when other New Hampshire hospitals were able to improve liquidity. While the current ratio shows that the hospital has enough current resources to cover its current obligations, the acid test, a more stringent measure of liquidity, reveals that these current resources are comprised of assets that are not highly liquid, mainly accounts receivable.

Days cash on hand measures further illustrate the hospital's weak liquidity, especially in a state where many hospitals were able to build large cash balances over the period. Franklin maintained a stable level of 12 days cash with short-term sources, while the state median increased slightly and was maintained at three times this level by 1998. With the inclusion of unrestricted marketable securities, the hospital has only 68 days unrestricted cash by 1998. However, vendor payments have remained in the range of a relatively normal 36-43 days.

Capital Structure

The trend in equity financing ratio (equity/total assets) illustrates the hospital's increased financial risk resulting from new long-term borrowing in 1995. Though the capital structure improved slightly after 1995 as a result of debt principal repayments, improvements were limited due to poor profitability.

The ability to service debt eroded due to deteriorating profit margins and may make it difficult for the hospital to maintain its debt service on current borrowings. The cash flow to total debt measure dropped dramatically after 1995, and dropped in half in 1998 following the hospital's losses. The hospital's ability to service debt principal and interest payments followed this same trend, and by 1998 the hospital is in a much weaker position to cover these payments with cash flow from net income. Further declines in profitability would create a solvency problem for this hospital.

Charity Care and Community Benefits

Charity care reported as charges forgone represented 1.6 to 2.9% of gross patient service revenues from 1993 to 1998. This amount of charity alone provided met the estimated value of the hospital's tax exemption with the exception of the hospital's most profitable years, 1994 to 1995, when the inclusion of 100% bad debt was needed to meet this benchmark.

The hospital did not report additional quantifiable community benefits in the footnotes to its financial statements.

According to the 1998 American Hospital Association Guide, Franklin Regional Hospital did not offer services that may be considered an additional charitable benefit to the community, such as the operation of a neonatal intensive care unit or trauma center.

Cash Flow Analysis 1993 - 1999

Franklin's pattern of cash flow is largely unchanged from last year. (See Cash Flow Analysis 1993-1998.)

1999 Ratio Analysis

Profitability

Franklin Regional Hospital's profitability continues to decline. The operating margin decreased from –3% in 1998 to –7% in 1999, and as of 1998, non-operating gains have no longer been able to offset these losses. Growth of expenses (11%) continues to surpass the growth of revenues (7%).

Liquidity

The hospital remains liquid, although its liquidity is declining. It is able to meet its short-term liabilities (current ratio: 3.64), although it can no longer meet them with cash reserves alone (acid test: 0.10). Franklin pays its vendors in an average of 33 days (very quick for hospitals in New Hampshire) and has 129 days cash on hand, including board-designated funds (slightly greater than the national average). While these indicators are good, days in accounts receivable has increased to 101 days in 1999 from 91 days in 1998, suggesting that Franklin has collection issues.

Capital Structure

The increase in long-term debt in 1999, combined with losses, is responsible for the decrease in the equity financing ratio to 0.47, from 0.58 in 1998. The long-term debt-to-equity ratio of 0.86 in 1999 has nearly doubled since 1998 (0.49). Franklin's inability to cover the current portion of its long-term debt with its cash flow (as indicated by its debt service ratio of 0.78) is an indicator of potential problems. Total cash balances of $8-9M equal long-term debt of $9M, so there is some cushion, but it can rapidly erode with continued operating losses.

Charity Care and Community Benefits

In 1999, charity care reported as charges forgone represented 1.88% of gross patient service revenue. This is down from last year's 2.86%. Additionally, bad debt represents 3.72% of Franklin's GPSR. The audited financial statements do not specifically define any other community benefits.

Summary

Declining profitability, slow collection, and increased long-term debt put this hospital in a financial position that cannot be sustained for long.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A., Harvard School of Public Health